



**Commission of
Correction**

**Final Report of the
New York State Commission of Correction:**

In the Matter of the Death of

**Stephanie Moore,
an incarcerated individual of the
Fulton County Jail**

June 25, 2025

**To: Sheriff Richard Giardino
Fulton County Sheriff's Office
2712 State Highway 29
Johnstown, New York 12095**

Allen Riley
Chairman

Yolanda Canty
Commissioner

Elizabeth Gaynes
Commissioner

GREETINGS:

WHEREAS, the Medical Review Board has reported to the NYS Commission of Correction pursuant to Correction Law, section 47(1)(d), regarding the death of Stephanie Moore, who died on December 28, 2023 , as a result of circumstances which occurred while an incarcerated individual in the custody of the Fulton County Sheriff at the Fulton County Jail, the Commission has determined that the following final report be issued.

FINDINGS:

1. Stephanie Moore was a 33-year-old female who died on 12/28/23 from an anoxic encephalopathy secondary to prolonged respiratory arrest following a fentanyl overdose incident that occurred on 12/26/23 while in the custody of the Fulton County Sheriff at the Fulton County Jail (CJ). The Medical Review Board has found that there were significant deficiencies in the medical care Moore received at the Fulton CJ along with failures by staff to order the proper interventions when Moore was found to be in an acutely intoxicated state prior to her death.

2. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] In the instant offense, Moore plead guilty to Burglary 2nd Degree and Petit Larceny and was awaiting sentencing at the time of her death.

3. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

4. On 10/2/23, Moore was received at the Fulton CJ. At 10:53 a.m., Corrections Officer (CO) T.B. completed Moore's suicide prevention screening in which she scored a '2' for [REDACTED]. CO T.B. documented on the initial risk assessment that referrals were made to Registered Nurse (RN) [REDACTED] for medical and to Forensic Case Manager (FCM) [REDACTED] for mental health. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

5. [REDACTED]
[REDACTED]

[REDACTED]

Moore was to be housed in South-2 housing unit. [REDACTED]

[REDACTED] During an interview with Commission staff, [REDACTED]

[REDACTED]

[REDACTED] RN [REDACTED] stated that the facility has a shared chart between medical and mental health and that any mental health documents should be in the chart.

6.

[REDACTED]

[REDACTED] The Medical Review Board finds that there were failures to properly refer Moore to the indicated services including MAT and mental health as neither had occurred since her admission on 10/2/23. Moore indicated at admission that she was a daily heroin user. Moore was not referred for an opioid use disorder screening as required by 9 NYCRR §7011.5(a) which states:

Without unnecessary delay, but no later than seventy-two (72) hours following a referral, an incarcerated individual shall receive a medical screening to determine if the individual suffers from a substance use disorder for which medication assisted treatment exists.

Additionally, there was no indication that Moore was placed on any opiate withdrawal monitoring protocol despite reporting a recent history of use. Moore also reported a history of Bipolar Disorder and Depression but the referral to a mental health provider upon admission was not followed up and Moore was not seen by mental health until after submitting a sick call request 20 days into her incarceration. During her incarceration, Moore was seen by both family and psychiatric nurse practitioners for her medical needs. Although within their scope of practices to provide services, there was no indication of any review or oversight by the jail physician which is required to be maintained by all jails per requirements of 9 NYCRR §7010.2(a) which states:

The county legislature, board of supervisors or similar county governing unit shall appoint a properly registered physician for the local correctional facility.

[REDACTED]

7. [REDACTED] However, there was no documentation provided to the Commission that indicated there was a corresponding provider order for such medication. This is a violation of the requirements of 9 NYCRR §7010.2(j) which states:

Adequate health service and medical records shall be maintained which shall include but shall not necessarily be limited to such data as: date, name(s) of inmate(s) concerned, diagnosis of complaint, medication and/or treatment prescribed. A record shall also be maintained of medication prescribed by the physician and dispensed to a prisoner by a staff person. [REDACTED]

8. [REDACTED]

9. [REDACTED]

10. [REDACTED]

11. [REDACTED]

12. [REDACTED]

13. [REDACTED]

14. [REDACTED]

15. On 10/29/23, CO T.B. documented [REDACTED] medication pass on the Controlled Substance Record. [REDACTED]

[REDACTED] There was no documentation provided to the Commission indicating a change in dosage or a reason for an additional dose provided for this day. During an interview with Commission staff, CO T.B. stated that this documentation was made by him for the purpose of documenting 8 mg of Suboxone being taken from Moore's prescribed medication stock and provided to another incarcerated individual but he could not remember to whom. CO T.B. stated that if an incarcerated individual were to run out of Suboxone, then he would contact the supervising officer who would contact NP [REDACTED] who would authorize the officer to pass the medication from another incarcerated individual's prescription stock to another incarcerated individual whose medication was out. CO T.B. stated that he would then create a note for medical on a post-it note or slip of paper to account for the medication transfer. [REDACTED]

[REDACTED] The Medical Review Board finds that this is an unacceptable practice and is most likely, in violation of New York State statutes and regulations regarding controlled substances.

16. [REDACTED]

17. [REDACTED]

- 17. [REDACTED]
- 18. [REDACTED]
- 19. [REDACTED]
- 20. [REDACTED]
- 21. From 11/11/23 through 11/23/23, there was no documentation of any [REDACTED] administration for Moore that was provided to the Commission. This is a violation of 9 NYCRR §7010.2(j).
- 22. [REDACTED]
- 23. [REDACTED]
- 24. [REDACTED]
- 25. [REDACTED]
- 26. [REDACTED]
- 27. [REDACTED]
- 28. [REDACTED]

[REDACTED]

29. [REDACTED]

30. [REDACTED]

31. [REDACTED]

32. [REDACTED]

33. [REDACTED]

34. [REDACTED]

35. [REDACTED]

36. [REDACTED]

37. [REDACTED]

[REDACTED] There was no documentation in Moore's medical records provided to the Commission that she refused to finish or declined the [REDACTED] at any time during this incarceration. This is a violation of 9

NYCRR §7010.2(j).

[REDACTED]

38. [REDACTED]

39. On 12/24/23, Moore was housed in the South-1 female dormitory.

40. On 12/24/23 at approximately 7:15 p.m., CO S.B. observed Moore receive a tampon shell from Incarcerated Individual [REDACTED] while both were in the toilet area of the housing unit. CO S.B. documented this observation and informed the two individuals they were not allowed on the toilets at the same time and for Moore to leave the bathroom. During an interview with Commission staff, CO S.B. stated that Moore moved away from the toilet and into the area of the microwave and CO S.B. moved her attention to another incarcerated individual but did not give this interaction much concern. CO S.B. stated that between this interaction and RN [REDACTED] entering the housing unit, Moore seemed okay on her housing unit watch tours. The Medical Review Board opines that the observation of Moore's furtive movements by the officer in housing area should have prompted a separation and securing of the two individuals plus an immediate notification to a supervisor in order to initiate a search procedure.

41. On 12/24/23, CO S.B. documented at 7:20 p.m., RN [REDACTED] entered the housing unit to begin medication pass when Moore was observed hunched over the table and was turning blue. Moore was unable to respond to another incarcerated individual verbally. During an interview with Commission staff, CO S.B. stated that at this time, Moore was experiencing lockjaw and was unable to speak. CO S.B. stated that she asked RN [REDACTED] to look at Moore. [REDACTED]

[REDACTED] CO S.B. initiated a code blue medical emergency response. [REDACTED]

[REDACTED] At 7:50 p.m., Emergency Medical Services (EMS) was activated. At 7:53 p.m., EMS assumed care of Moore. [REDACTED]

[REDACTED] During an interview with Commission staff, CO S.B. stated that after Moore was provided Narcan, CO S.B. informed her supervisor what she had observed in the toilet area between Moore and Incarcerated Individual [REDACTED] earlier in the day. CO S.B. stated that Incarcerated Individual [REDACTED] had gone to visitation that day and had been strip searched

prior to her return to the housing area but something occurred between the two incarcerated individuals.

42. On 12/24/23 at 10:19 p.m., Moore returned to the facility from Nathan Littauer Hospital [REDACTED]. Moore was housed back on South-1, the female dormitory. CO A.S. documented at 11:10 p.m. that she observed Moore to be acting off, like something was wrong. Documentation indicated that CO A.S. contacted Corporal J.W. CO A.S. observed another incarcerated individual holding Moore up and putting wet wash cloths on her. At 11:20 p.m., CO A.S. called a code blue to South Housing. During an interview with Commission staff, CO A.S. stated that Moore had come up to the officer's station and was acting off. Moore was talking to CO A.S. and five or ten seconds later, Moore dozed off on the desk and then woke up and spoke a complete sentence and then went back into 1-South. CO A.S. reported that incarcerated individuals stated that Moore was "doing it again" and was going in and out of consciousness. CO A.S. stated that she called a medical code and held onto Moore by her chest. CO A.S. was not sure if Moore was breathing at that time, but Moore responded to Narcan and began talking. During an interview with Commission staff, Corporal J.W. stated that he grabbed Narcan with the knowledge that Moore went to the hospital earlier in the day. Corporal J.W. indicated that he was not sure if Moore had obtained anything else but Moore was unresponsive. At 11:22 p.m., Moore received the first dose of Narcan and within about 20 seconds, showed a little response. A second dose of Narcan was administered and Moore showed a response that include talking to security. However, Moore passed out again prompting a third dose of Narcan being given. Moore became responsive and angry [REDACTED]. Moore was escorted to the holding cell area. [REDACTED]. [REDACTED]. During an interview with Commission staff, Corporal J.W. stated that while he was talking with NP [REDACTED]. providing an update which included that Moore refused to go to the hospital, Moore stated that there was no reason to Narcan her. NP A.G. informed Corporal J.W. to place Moore on constant observation until she could be seen by medical in the morning. The Medical Review Board opines that Moore was still showing signs and symptoms of acute intoxication and should have been returned to the hospital for treatment. Additionally, the Board finds that there was a failure by NP [REDACTED] to provide clear direction to corrections staff on when to send Moore back to the hospital if her condition was not improving. During an interview with Commission staff, Corporal J.W. stated that the constant observation occurred in Medical Cell 1. Corporal J.W. indicated that Moore was up talking with the officer all night complaining about being alone and being off her housing unit. Constant observation was documented through the night at 15-minute intervals through 9:55 a.m.

43. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] There was no documentation of any assessment of Moore to be cleared from medical housing or of the communication between RN [REDACTED] and NP [REDACTED]. This is in violation of 9 NYCRR §7010.2(j). The Medical Review Board opines that since Moore needed to have Narcan administered four times in less than 24 hours which resulted in two code blues being called, Moore should have received a medical assessment from the facility medical provider prior to being removed from constant

supervision.

44. At 10:01 a.m., Moore was documented in the housing area logbook as returned to South-2 Cell 7. At 10:28 a.m., RN [REDACTED] was documented in the housing area logbook as being on and off the housing unit after speaking with Moore. At 10:52 a.m., Moore was documented in the housing area logbook by CO V.M. as appearing okay at the dayroom table on a tablet.
45. On 12/25/23 at 12:30 p.m., Moore went to recreation. At 1:30 p.m., Moore returned from recreation.
46. On 12/25/23 at 3:57 p.m., CO S.B. documented that Moore remained “out of it” pertaining to her speech and movements. Moore was instructed by the officers to go to her cell and lay down and Moore complied.
47. On 12/25/23 at 5:02 p.m., CO S.B. documented speaking with Corporal L. about Moore and how she was still very “doped up.” CO S.B. did not feel that Moore should remain on the second floor of the tier as it would have been easier to watch her continually if she were by the door in 1S. At 5:26 p.m., CO S.B. documented her conversation with Corporal B. pertaining to her being uncomfortable with Moore being in South-2. Moore was still very lethargic and unsteady on her feet.
48. On 12/25/23 at 5:32 p.m., Moore was documented as going to medical and returning to the housing area at 6:12 p.m. A review of Moore’s medical record by the Medical Review Board indicated that there was no documentation provided for this encounter. This is a violation of 9 NYCRR §7010.2(j).
49. On 12/25/23 at 8:06 p.m., RN [REDACTED] was documented as being on the housing unit for [REDACTED]
50. On 12/25/23 at 9:23 p.m., CO S.B. documented speaking with Moore as she was informed by other incarcerated individuals that Moore was still out of it. The incarcerated individuals were concerned that Moore was doing more drugs and CO S.B. believed it was a mix of her 8:00 p.m. medications and the residual effects of Moore’s overdose. At 9:32 p.m., CO S.B. documented a late tour due to dealing with Moore and trying to get her to go to bed and the concerns of the other incarcerated individuals. During an interview with Commission staff, CO S.B. stated that she informed CO A.S., who was assuming control of the housing unit, that if she felt uncomfortable with Moore being on the second floor, she should annotate that and inform the supervisor. CO S.B. stated that she informed CO A.S. that Moore still seemed to be drugged up but was not on any increased observations at that time. CO S.B. stated that through the night, Moore seemed to be getting worse and informed CO A.S. as to her observations of Moore.
51. At 9:46 p.m., 10:00 p.m., 10:28 p.m., and 10:57 p.m., Moore was documented as being okay in her cell.
52. On 12/25/23 at 10:57 p.m., CO A.S. documented that Moore was observed sitting on the toilet and appeared to be asleep. CO A.S. woke Moore up and made sure that Moore answered the officer before the officer continued their tour. CO A.S. completed two more tours in which Moore was documented as being ok. At 11:23 p.m., CO A.S. documented contacting Corporal J.W. as CO A.S. was uncomfortable about Moore being on the top

tier. Moore had puffy eyes and was falling asleep standing up. At 11:40 p.m., CO A.S. documented completing a watch tour with Moore being ok. During an interview with Commission staff, Corporal J.W. stated that when he did his watch tours of the South housing units, he observed Moore sitting on her toilet watching television. Corporal J.W. stated that he asked Moore how she was doing to which she replied, "okay." Corporal J.W. stated that Moore seemed perfectly fine at the time. During an interview with Commission staff, CO R.M. stated that she began her shift as the roving officer assisting the supervisor. CO R.M. indicated that she was on the South housing unit to distribute indigent materials to incarcerated individuals. CO A.S. informed CO R.M. that she was uncomfortable with Moore's presentation. CO R.M. stated that she performed a housing area watch tour that included talking with Moore. During this conversation CO R.M. asked Moore if she took anything and stated that Moore would not be in trouble but would get help if needed. Moore responded she had not, and that she was sleepy. CO R.M. stated that by the time she made it back to the officer's station, Moore had fallen asleep again. CO R.M. went back to Moore's cell again and at that time, Moore stood up and got off the toilet.

53. On 12/26/23 at 12:07 a.m., CO A.S. documented completing a watch tour with Moore listed as "ok." At 12:13 a.m., CO A.S. documented that Moore was standing on the toilet and was advised that she cannot do that for her safety. Moore complied and got down off the toilet. At 1:15 a.m., CO A.S. documented while conducting a watch tour, Moore informed her that she fell off the toilet and hit her nose. CO A.S. advised Corporal J.W. and Moore was provided an ice pack. During an interview with Commission staff, Corporal J.W. stated after this incident, he approached Moore and asked what was going on. Moore stated that she was watching television and nodded off. Corporal J.W. inquired if Moore needed to be seen at the emergency department. Moore declined and stated that her night medications make her sleepy and that she just wanted some ice. The Medical Review Board opines that Moore had documented signs of acute intoxication for over eight hours, needed to be returned to constant supervision, and evaluated by a physician or sent to the hospital. The failure to elevate Moore to constant supervision is a violation of 9 NYCRR §7003.3(h)(1-3) which states:

The chief administrative officer and/or the facility physician shall determine whether a prisoner requires additional supervision based on the prisoner's condition, illness or injury, and the chief administrative officer shall order such supervision if warranted.

Additional supervision may include:

- (1) more frequent supervisory visits;*
- (2) active supervision when only general supervision is required; or*
- (3) constant supervision.*

54. CO A.S. conducted watch tours and observation of Moore at 1:47 a.m., 2:13 a.m. and 2:40 a.m. with Moore being documented as "ok." During an interview with Commission staff, CO A.S. stated that during the 2:40 a.m. tour, she observed that Moore was breathing. CO A.S. stated that she stopped and made sure that Moore was breathing while laying down in her cell. CO A.S. indicated that it was stated to CO R.M. that Moore had finally laid down and went to sleep and informed CO R.M. that she had been keeping an eye on Moore. CO R.M. documented at 2:57 a.m., that she assumed control of the South Housing Unit from CO A.S.
55. During an interview with Commission staff, CO R.M. stated that a few minutes later, she

began her watch tour in South-2 by walking up the stairs to cell six and then to Moore's cell number 7. CO R.M. stated that she observed Moore but was not sure if she saw any movement. CO R.M. stated that she stopped and continued looking for movement and requested Moore's door to be opened in order to confirm. CO R.M. entered the cell calling Moore's name. CO R.M. stated that she turned Moore over by grabbing her shoulder and found that Moore was unresponsive.

56. On 12/26/23, CO R.M. documented in an incident report that CO R.M. observed Moore lying face down on her stomach with her head tilted towards the wall with her left leg straight and her right leg slightly bent. CO R.M. did not observe any movement or breathing. CO R.M. called Moore's name a couple of times with no response. CO R.M. entered Moore's cell and grabbed her right shoulder to roll her over. Moore's body was completely limp, and her face was blue around her lips. At approximately 3:05 a.m., CO R.M. called an emergency code blue. CO R.M. requested via radio that Narcan be brought to the unit and then she moved Moore to the floor of her cell. CO A.S. arrived followed by Corporal J.W. and CO N.P. The first dose of Narcan was administered. CO N.P. then administered a sternum rub followed by a second dose of nasal Narcan with no response. CO R.M. attempted to palpate a pulse but could not locate one. At 3:06 a.m., CO R.M. began cardiopulmonary resuscitation (CPR). A third dose of Narcan was administered. At 3:07 a.m., the medical bag arrived, and the mouthpiece was used to give rescue breaths to Moore. At 3:09 a.m., EMS was activated. Corporal J.W. retrieved the automated external defibrillator (AED) which was applied at 3:11 a.m., but there were no shocks advised. At 3:12 a.m., EMS was dispatched. CPR continued.
57. At 3:18 a.m., EMS arrived and assumed care of Moore. CO R.M. continued with CPR including rescue breaths until Moore was intubated. During an interview with Commission staff, Corporal J.W. stated that while staff and EMS were performing resuscitation attempts, Moore showed no signs of life. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
58. On 12/26/23 at 3:28 a.m., CO R.M. documented a watch tour with Moore being ok. At 3:38 a.m., CO N.P. documented performing a cell inspection with video of Moore, this was performed in South-2 cell 7 to document the condition of the cell post terminal event. At 3:49 a.m., CO N.P. documented a watch tour with Moore being ok. At 3:50 a.m., CO N.P. documented that Moore was taken to the hospital. [REDACTED]
[REDACTED] At 3:57 a.m., CO N.P. documented a watch tour with Moore being ok. During an interview with Commission staff, CO R.M. believed that these documentations were done during and after the rescue attempts. CO R.M. indicated that the computer will alarm for watch tours and someone from security must have marked them to turn the alarm off.
59. On 12/26/23 at 8:50 a.m., CO J.R. documented that the [REDACTED]
[REDACTED]

-Why Moore's removal from the MAT program was not in comportment with 9 NYCRR §7011.5(d).

-Why Moore was not placed on increased or constant supervision when she was documented as having obvious signs of intoxication in comportment with 9 NYCRR §7003.3(h)(1-3)

-Why Moore was removed from medical constant supervision without an assessment from a medical provider on 12/25/23.

2. The practice of using controlled medications prescribed to one individual and administering the controlled medication to another individual in order to cover a medication shortage shall cease immediately. The Medical Director shall revise the facility's policy and procedure to reflect this and shall implement proper policies for obtaining medication orders and backup orders of medication.

A report of the findings and any corrective actions taken shall be provided to Commission upon completion.

In a response dated 4/30/25 to the Commission's preliminary report, PrimeCare Inc. the newly appointed medical provider service as of 1/1/25, indicated that the requested reviews were completed with corrective action training taken with staff. Compliance with the actions required will be verified by the Commission at a later scheduled health services evaluation.

TO THE CHAIR OF THE FULTON COUNTY LEGISLATURE:

As the appointing authority for the delivery of jail incarcerated individual health services pursuant to Correction Law section 501, the County Legislature shall review the above findings and conduct an inquiry into the fitness of the formally designated provider.

WITNESS, HONORABLE YOLANDA CANTY, Commissioner, NYS Commission of Correction, Alfred E. Smith State Office Building, 80 South Swan Street, 12th Floor, in the City of Albany, New York 12210 on this 25th day of June 2025.



Yolanda Canty
Commissioner
Commission of Correction

YC:MB:vc
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